ORIGINAL

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: HOME HEALTH TECHNICAL ADVISORY COUNCIL

July 27, 2016
11:00 A.M.
James Thompson Training Room
Cabinet for Health & Family Services
275 East Main Street
Frankfort, Kentucky 40601

APPEARANCES

Sharon Branham
CHAIR

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Billie Dyer
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Joyce Lewis
Darlene Litteral
Brian Lebanion
PROFESSIONAL HOME HEALTH CARE

Reed Welker
Matthew Wilkinson
MAXIM HEALTHCARE

Appearing Telephonically:

Kathleen Ryan
ANTHEM

Juan Abreu
Julie Jennings
HUMANA-CARESOURCE

AGENDA

OLD BUSINESS:

Many denials for medical supplies for agencies because MCOs are requesting denial from Medicare although Medicare does not generally provide denials for a patient who does not have a Medicare skill

Denials received by Home Health providers for supplies exceeding the limit

Exceedingly long prior authorizations for therapies provided by agencies

NEW BUSINESS:

MWMA:
* Inability to transition patients under either system
* Exceedingly long period of time for closures
* Numerous errors being reported with case notes, inability to addition transitions, unable to open tabs which should be in place are not which prevents entering of patient information
* Lack of knowledge from CSR who should be trained to answer questions

HCBW:
* Longer than usual amount of time to process 552
* No assistance to expedite 552
* Disconnect from DSS and Medicaid
* Patient addresses (incorrect from other resources) unable to assist with change and information cannot be entered

Private Duty:
* Please provide update to TAC on possible changes related to Waiver 1115 and any changes to program that may be on the horizon

OTHER BUSINESS:

MS. CARTRIGHT: Sharon is running a little late, so, she asked me to get us started. I just want to remind everybody this is an open meeting, however, you have to be on the TAC committee to speak.

So, we will go ahead and if I can get everybody to go around the room and state who you are and who you are with and then we'll take it from there.

(INTRODUCTIONS)

MS. CARTRIGHT: We all have a copy of the minutes. So, if you want to review those and let me know if we have a motion to accept.

MS. JENNINGS: Do you know if those minutes were sent out? I didn't see anything on the website.

MS. CARTRIGHT: I do believe they were sent out.

MR. EASTHAM: Yes, they were sent out. I haven't had an opportunity to get them up on the website. We're working on that right now. There's a little snag there. They will be up.

MS. STEWART: I'll make a motion.

MS. CARTRIGHT: Susan has made

a motion to accept. Do I have a second?

MS. BONSUTTO: Second.

MS. CARTRIGHT: Thank you. It looks like under Old Business we have without resolution the denials for medical supplies for agencies because MCOs are requesting denial from Medicare although Medicare does not provide denials for a patient who does not have a Medicare skill.

Do we have anything from the MCOs?

MS. ARFLACK: Are they all doing it or is it just one in particular?

MS. CARTRIGHT: I don't know. I don't have the particulars.

MS. ARFLACK: It would help us in Medicaid if we knew which MCO so that we can work with them on that.

MS. CARTRIGHT: Sharon probably has that when she gets here.

MS. ARFLACK: Okay, because I looked at this and I was like, well, I didn't know which one and what the issue was.

MS. RYAN: And I believe last time there was going to be identification of claims and them being sent out to the individual MCOs if

there was an issue but we weren't aware of what the issue was.

MS. CARTRIGHT: Okay, and you didn't receive anything. Is that what you're saying?

MS. RYAN: No. Correct.

MS. ARFLACK: It says in the minutes that they're going to send them examples and I guess Sharon was going to forward them to DMS staff. That's what we would like is specific examples.

MS. CARTRIGHT: Right. And I guess the next one, denials received by home health providers for supplies exceeding the limit.

MS. STEWART: I think that was WellCare.

MS. JAMISON: I'm pinch-hitting for Pat which is all I can pretty much speak on that but I will bring it back to her. She is on vacation this week. I know she was looking into that.

MS. ARFLACK: Did you get any examples or anything?

MS. JAMISON: No, not that I know of. She might have it.

MS. STEWART: She left with examples that day.

MS. ARFLACK: Okay. Then, that lets me know Pat has got it.

MS. JAMISON: She has probably already done so. Thank you.

MS. STEWART: In conjunction with that, are you all seeing that home health agencies are running the supplies through DME companies as opposed to home health agencies?

MS. JAMISON: I am not aware of it on my side.

MS. ARFLACK: There seems to be some of that.

MS. STEWART: Because we're getting a lot of denials for excessive supplies.

MS. ARFLACK: So, you think they're running it through DME.

MS. STEWART: I'm thinking it could be better off if I gave it to a DME because maybe they can do something that we can't. I just wanted to know if----

MS. ARFLACK: Because their limits are higher?

MS. STEWART: Not necessarily.

I don't know. I don't know what----

MS. ARFLACK: You don't know what the difference would be?

MS. STEWART: Right. I'm trying to find out. So, do you know if that's happening?

MS. JAMISON: No, I don't know.

MS. ARFLACK: This is what I was going to ask. Would it be helpful if they provided you the--I mean, do you know the limits for your home health?

MS. STEWART: It's $250.

MS. ARFLACK: Okay. So, it's a set amount.

MS. STEWART: Yes.

MS. ARFLACK: So, it's $250 on everything?

MS. STEWART: I think per line. Is that what it is?

MS. JAMISON: I don't know.

MS. STEWART: I think that's what it is.

MS. CARTRIGHT: It varies with the MCO.

MS. ARFLACK: But we're dealing with WellCare right now.

MS. STEWART: Particularly with WellCare, it's $250, yes.

MS. ARFLACK: So, if it's $250 you're saying and maybe DME has a higher----

MS. STEWART: Possibly. I don't know but I have heard that that's what some of the home health agencies across the state are doing.

MS. ARFLACK: Is they're just running them through the DME.

MS. STEWART: They're sending the order for the supplies to a DME company and they're just using their supplies in conjunction with their visit and it's up to the patient to get the intermittent supplies between that visit and the next visit. I'm just seeking information. I don't really know.

MS. ARFLACK: You're trying to figure out why the limit is $250.

MS. STEWART: No. I'm trying to figure out if that's acceptable; and if so, we need to figure out how to make it work because this right here is on here every time and we haven't got a resolution. So, if that's a possible resolution,

we share it with the world and everybody would have less denials.

MS. ARFLACK: There's folks here from Humana, I noticed. Do you all see they're running it through DME? Are you all familiar?

MS. HIATT: Julie, Juan?

MS. JENNINGS: We actually have those. We have home health agencies that do send in prior auths for the supplies. So, we do also see them, but we also have DME companies that also mail out the supplies to the member. So, we have both situations and I haven't come across any issues as far as I'm aware.

MS. ARFLACK: Do you all have a limit on your home health supplies?

MS. JENNINGS: We do, and ours is usually along the same lines as what's on the KDMS website for the fee schedule.

MS. BONSUTTO: I know we have started sending all of our MCO Medicaid or Medicare managed care supplies through a separate vendor, through a third-party vendor so that we don't have that kind of loss. So, they're setting up with the patient because some contracts, some of the Medicare managed care contracts pay for it but most of them

do not, but even with the Medicaid MCOs. So, we're going through a separate supply company and we're not getting that authorization anymore.

MS. RYAN: This is Kathleen Ryan with Anthem. Ours is similar to what Julie is saying. We accept the request from home health or DME. There's not a difference in benefit, the same benefit level. It's just the convenience for the member. However it is submitted to us is what we respond to.

MS. ARFLACK: It sounds like they're all doing it.

MS. STEWART: It sounds like it.

MS. CARTRIGHT: The next item on the Old Business Without Resolutions, the exceedingly long prior authorizations for therapies provided by agencies.

MS. ARFLACK: Can you help me a little bit on that?

MS. STEWART: I think it's taking----

MS. ARFLACK: Too long. Okay. That's what I thought. I was thinking, you all never said that you got too long. I'm sorry.

MS. STEWART: I think it's two to three weeks before they get the prior auth.

MS. ARFLACK: We need specific examples of that because they are held to a two-day. Now, if they ask for more information, but if they don't give you an answer within two days, then, we need to know about it because they're out of compliance.

MS. CARTRIGHT: Because I know I've had that in my agency.

MS. BONSUTTO: That's a common problem.

MS. ARFLACK: Are they losing them? Okay. Another organization came to us and said, when we send stuff off, it never gets in on a fax. Well, we're testing fax machines now. We do a periodic, just fax something in, see how long it takes to get a response. So, we're testing that to make sure because that is a common complaint. They don't find it. They don't know. They don't--I mean----

MS. CARTRIGHT: Never saw it.

MS. ARFLACK: Never saw it. So, we're testing that up in Medicaid. So, if you've got that and you get a reply that your fax

was received and you don't get any response, I'm talking crickets, after two days, then, they're out of compliance.

MS. DYER: So, what about the response, that we've got 14 days to respond to which that's happened to us? That's not right.

MS. BONSUTTO: And, then, the patient can't get service. We've got physician orders----

MS. ARFLACK: Right. If you've got somebody coming out of the hospital that needs----

MS. BONSUTTO: And I can't wait 48 hours to see them because I've got a timely started care issue and I need to go see them and medically they need to be seen the next day, and we're not being able to take care of those patients and that's causing re-hospitalizations and it's costing more money and it's affecting our outcomes.

So, eventually, we're making the decision whether we're going to just not accept those patients from the MCOs because we can't wait.

MS. ARFLACK: We've had a lot of members switching. You know, the member issue that we had earlier in this year, we had a lot of

member issues, but those are starting to be less and less. So, those I understand. They don't know whether they really have this member or they're kind of unsure. Those I can understand, but, still, they're still under the two days to turn around.

MS. DYER: It was no exception, no 14-day. And it can be on admission, but it can be on continuing as well. So, then, you've got the order. You're obligated to go. That's what regulatory tells us, that you're obligated to go do the visit because you've got the order to go do it. So, you have to go, not knowing what's going to happen, and we've had issues with that. I think everybody has.

MS. ARFLACK: I want to make sure I understand. So, they tell you----

MS. CARTRIGHT: You have five visits, per se. And, then, if the therapist goes out and they feel like the patient is either not progressing or needs a few more visits, so, then, we send in another request----

MS. ARFLACK: Another prior authorization but the first one was given five visits, right?

MS. CARTRIGHT: I'm just using

that as an example.

MS. ARFLACK: Well, I just need to know. The first one, though.

MS. CARTRIGHT: The first one had five visits. So, then, when you go and you send off for the next whatever you're requesting, sometimes that also takes up to five, six, seven days. And, again, you have a patient sitting there. We usually go out, but we have been burned where we have gone out, provided care, the patient needs the care and then get denied the visits because they weren't prior----

MS. BONSUTTO: You didn't get authorization. Yep, we've got tons of those.

MS. CARTRIGHT: And, so, you can't----

MS. ARFLACK: You can't guarantee. You can't provide services until you get that prior authorization.

MS. DYER: Well, regulatory says you do because you have an order.

MS. CARTRIGHT: Regulatory says you do because you have an order and the patient needs it.

MS. BONSUTTO: So, the OIG is

saying you have to go do that care even though we don't have auth. And, so, is the delay because they know we have an obligation to do the care, and, so, they just want to have it free because then when you do it, even though you submitted it and there's no auth, and, so----

MS. ARFLACK: Now, are they asking for more medical--I mean, because we say medical necessity.

MS. DYER: No. It's just we have this long a period of time and----

MS. CARTRIGHT: That's it.

MS. DYER: And then there's a gap. It can take varying amounts of time from a small amount to a large period of time, but my staff and what I am hearing from these ladies, we have been told that it can take up to 14 days to get that auth and they have that long. So, you're saying that's not correct.

MS. ARFLACK: No. They have to respond in two days to a prior authorization. And they can respond and deny it or they can respond and approve it or ask for further information. That's a response in our world.

MS. STEWART: And asking for

further information is deemed a response?

MS. ARFLACK: That's deemed a response. So, if they ask for further information on every one of them, then, that's----

MS. DYER: It's not that. It's just a gap. All of the above happens, but this particular problem can be a gap, how long it takes.

MS. ARFLACK: They're out of compliance if they don't respond.

MS. CARTRIGHT: So, any request, they have 48 hours to respond.

MS. ARFLACK: Yes. They have two days.

MS. CARTRIGHT: Is it two days or two business days?

MS. HIATT: It's business days.

MS. CARTRIGHT: Okay. So, that could be problematic if you do it on a Friday.

MS. ARFLACK: If you do it on a Friday and you don't get a response. And what time it's received. You know, if it's received at 4:30 on a Friday.

MS. CARTRIGHT: Well, sometimes we don't get the referrals until 4:30 on

Friday and they have to be seen.

MS. ARFLACK: Right, but they're supposed to have a process. It should be emergency, if it's an emergency.

MS. CARTRIGHT: Do we need to put that on our request that it's an emergency if we get something Friday afternoon late in the afternoon?

MS. ARFLACK: I would. I mean, if it's a Friday afternoon and they've got to be seen. I mean, if they have--I mean, I'm just--you know, I'm not clinical -you all have to understand - but if you've got an open wound or something that somebody has come out of the hospital and they've got to have treatment.

MS. BONSUTTO: Well, any patient that comes out needs to be seen almost always within 48 hours. And if they're coming out of a facility, they really should be seen the next day from a nursing standpoint. I mean, that's the right thing to do for the patient and that's sort of the expectation.

So, is there a written process that is there for when we have a patient that needs to be seen within 24 hours so that we can get

approval?

MS. ARFLACK: I think each MCO should be able to provide you what their--I mean, it should be out there on their website. Do you all have something written out there on your website?

MS. BONSUTTO: Do you all have a requirement in their contract that they have to have something set up to respond back to us for these patients that need to be seen the next day regardless of what day of the week it is? I mean, we're open seven days a week taking care of patients 24 hours a day.

And if I get a referral, and I can tell you, Friday afternoon is when we get all these referrals because they're all going out of a hospital, and if what we have to do is to put every single one of them and remember to put them as an emergency or otherwise or you're not going to answer me back until Tuesday which means they're not going to get care until Wednesday, that's - Saturday, Sunday, Monday, Tuesday, Wednesday - five days before they're going to get care. And I will tell you, 10, 20% of them are going to end up back in the hospital.

MS. CARTRIGHT: Before you

even get out there.

(Ms. Branham arrives)

MS. BONSUTTO: Right. And I'll just tell them to wait to get the order if I have to to cover myself from a regulatory standpoint. I give an order for the patient to be hold until we get approval so that they're not my patient, but I can't imagine that an MCO wouldn't be interested in the thousands and thousands of dollars it costs for rehospitalization for finding a process to put in to give approval to care for the patient.

MS. RYAN: Kathleen with Anthem. First off, I hear what you're saying and you feel there is a concern in delay. And certainly if you've got examples, we want to address that. I feel we are very timely with the two-day business turnaround.

And we really do want to escalate any discharge planning. When patients get out of the hospital, we do want to escalate those. So, if you mark that on your fax or if you want to call that in, then, we'll put it through quicker when it is a discharge planning or if you feel that there's an urgency with the care needed.

But I'm hoping and I do feel

that we are very timely and look forward to looking at any claims or issues if you feel we are not being compliant.

MS. BONSUTTO: Well, I can't wait two days on a patient that's coming out of the hospital. I guess that's my point. And then when my providers are calling, they're sitting on hold for 45 minutes waiting just on hold and they've got a job to do. I can't do that for every single one of them.

MS. RYAN: And I hear you. That would be a problem.

MS. BONSUTTO: So, do you all have an expedited line for those emergency patients that we could call that we could talk to a live body? That would be a solution.

MS. ARFLACK: They have an expedited process.

MS. BRANHAM: What about presumptive eligibility? We're not doing that? I mean, we've got us a plan to do that was signed and we have PE for----

MS. ARFLACK: That's not going to solve this prior authorization problem.

MS. BONSUTTO: We're talking

about MCOs, not waiver.

MS. ARFLACK: I mean, they're eligible. That's not the problem.

MS. BRANHAM: They're eligible, right.

MS. ARFLACK: But we're trying to get the prior authorization is what we're talking about, Sharon.

MS. BONSUTTO: But I think she's talking about is if they come out of a hospital----

MS. BRANHAM: A facility, why doesn't that work?

MS. BONSUTTO: ----couldn't you already create a prior skilled need coming out of the hospital?

MS. STEWART: I thought presumptive eligibility meant----

MS. ARFLACK: What we're trying to do is get somebody eligible just temporarily until we can get them on our files. Presumptive is trying to get them in the system because there's an emergency and there's some issue that needs to be taken care of very quickly until we can get them on our files.

MS. BONSUTTO: I think what she means is an automatic authorization process. In other words, if somebody is on vacation and you go see the patient the next day, is there not a way that the Department could say, well, that's an automatic back authorization?

MS. ARFLACK: This is out of our jurisdiction. Like I said, we're trying to work with the MCOs and we'll look at any issues if they're not getting their prior authorizations within two days.

And they have an expedited process. So, if they're not following their expedited process, then----

MS. BRANHAM: Okay. Do we know the expedited process, then?

MS. BONSUTTO: She said it's in each of their contracts. I don't know. I'm going to look. I wrote it down. I'm going to go check each one of them and make sure.

MS. ARFLACK: Well, it should be on their website. Isn't it on your website?

MS. HIATT: That's what I'm looking for.

MS. BONSUTTO: And what's the

penalty for not following the expedited process? If they didn't send me back anything, am I automatically going to get paid for the care because they didn't respond?

MS. ARFLACK: The penalty, what we do is we write a letter of concern. If we're not satisfied with what they give us back, then, we do a corrective action. And, then, if we're still not satisfied and they're not fixing the problem, then we go to sanctions and that's money out of their bank.

MS. BONSUTTO: But I'm still doing free care. There's no way for me to get recouped for the care that I did because I didn't get a prior authorization. Okay.

MS. ARFLACK: We're just the compliance piece. I can't help you get that paid. I can tell them they're out of compliance and they should pay that.

MS. BRANHAM: So, every MCO has the expedited authorization for hospital discharges to home health agencies for care?

MS. BONSUTTO: She says they should.

MS. ARFLACK: They have an

expedited process for the prior authorization. I don't think it's specific to----

MS. BRANHAM: Well, I mean, if it's a prior auth, whether it's from, you know----

MS. BONSUTTO: So, does everybody know if that's available for us to review? She is from Humana-CareSource. She's looking. She can't find it.

MS. HIATT: I'm trying to find the whole website on my little screen.

MS. ARFLACK: Why don't you all recommend that they bring it to the next meeting.

MS. BRANHAM: Absolutely. I'd like to make the recommendation that all MCOs bring to our next meeting their expedited process for prior authorizations for services. And, then, if it can be made available prior to our next meeting, then, I can provide it as part of the meeting information distributed.

MR. ABREU: This is Juan from Humana-CareSource. That's fairly easy for us to provide. I do want one quick clarification. If a service has already been rendered, that is retrospective. In some cases, we get one marked as

urgent or needs to be expedited, but, in fact, the service has already been rendered. So, that is now a retro. So, there's a difference there. I want to make sure that the providers understand this.

MS. DYER: And part of that expedited process needs to be what happens with the retro because what people are explaining is is you get a referral on Friday that you're going to take and it has to be seen, but you're not going to hear from it until Monday.

So, what I'm hearing you say, then----

MS. BRANHAM: That becomes retro, not----

MS. ARFLACK: I don't see that being retro. If you put it in on Friday, I don't see that being retro.

MS. BRANHAM: Juan, I wouldn't think that's retro. I think that would be a continuation of a service.

MR. ABREU: That scenario there that you're describing is a prior authorization. What I'm saying is if I receive a request on a Friday for a service that was rendered on Wednesday, that is a retro.

MS. BRANHAM: We don't really do that. That's not even being addressed right now. What we're talking about is trying to provide services as quickly as possible.

MS. BONSUTTO: We'll send in an auth on Friday and then do the care on Saturday and then follow back up on Monday and either say we never received the auth that you sent us or you did care and we haven't authorized it yet, so, it's denied. That's the process that is happening.

And, Juan, I would love to have a contact from you that my organization could sit down and go over the thousands and thousands of dollars I've got sitting out there to look at to determine about getting retro authorization and payment for.

MS. ARFLACK: Some of these issues that you all are discussing, these old issues, maybe these ought to be some recommendations.

MS. BRANHAM: Well, we recommend them and then we get some resolved for a small amount of time and then they come back. I often say that, Cindy, in these meetings, that I feel like I can just continue on with Old Business

because as soon as we get something lined out with the MCOs, it pops its head up again.

MS. BONSUTTO: I would like to recommend that the next time that you all update MCO contracts, that you put in there a requirement for a live line for immediate needs of authorization for those people who are coming out because transition of care is such a big issue right now to decrease cost and do that. And everything either has to go through a website or if you call, you would be on hold for a quite a long time or you have to fax it. So, that would be a recommendation for the next time that you guys are going to----

MS. BRANHAM: Well, that would be January of '17, and your recommendation is a live line for all?

MS. BONSUTTO: Is that they have to have a live line that's open 24 hours a day for emergency authorizations for patients that need to be seen within 24 hours.

MS. ARFLACK: I'm writing it down.

MS. BRANHAM: I've got it, too.

MS. ARFLACK: I want to make

sure, though, that if you get a response from the MCOs, they've received your fax, then, that's your now time table. Two days from there, that's when we need to know. Okay?

MS. BRANHAM: Yes.

MS. BONSUTTO: It's just tough because I've got lots and lots of people out there doing this across the state and I don't get paid enough money to care for the patients in the first place. So, then, to do additional administrative work to send all this stuff----

MS. ARFLACK: I don't need every one of them. I just need one. That's all I need. I just need one or two. I don't need like 25 because it doesn't matter if there's one or 25. They're out of compliance.

MS. BRANHAM: Okay.

MS. DYER: Do you want that sent to you?

MS. ARFLACK: Yes. And I've got business cards. I'll give them to you after the meeting. Sharon has my email.

MS. BRANHAM: Yes, I do. I can circulate it to you all.

I guess we're on the prior

authorizations, but back up to the fact that we get denials because they request an EOB from Medicare, and this is something that I thought we have had lined up over the course of the past five years, but agencies are continually being denied for not having an EOB from Medicare even if it's coded correctly for codes that they said that we should utilize to let them know that it's not a billable service to Medicare.

And we do that and then it comes back and it's denied. And I guess the thing, I would think as long as we have been into this now, that the MCOs would have this information down and communicated to their workers reviewing these, knowing that this is not something that is necessary, and the MCOs come in to this meeting and they say, no, it's not.

And, then, we give them examples and then they get worked through, and then it comes back again and that's what folks--when you put out a call for questions, it's like we're still getting denied for supplies, still getting denied for supplies because they would like to have a denial from Medicare. We can't always get a denial from Medicare, and I thought the code provided what

we needed to inform the MCO it's not a billable service.

So, enforcing these little nuances on down through there is what----

MS. ARFLACK: Well, you all now have a process. Starting the first of August, you all have the appeal process through the MCOs. After you've appealed everything through the MCOs, you can come now through the process that we have developed.

It's in my division. It will be in our division. We are staffing up for this and it will come through the MCOs. You will tell the MCOs I want this appealed after you've exhausted all their appeals and it will come over to us.

And we have outside entities that will be reviewing these for medical necessity, so, medical doctors, not just Medicaid staff. We're going to have two nurses that will be reviewing-- there's going to three buckets that you will pick and we're going to send the process out.

MS. BRANHAM: Well, that's helpful.

MS. ARFLACK: So, this will give you another avenue because you all have not had

that.

MS. BRANHAM: Yes. That's helpful to us.

MS. BONSUTTO: Can I ask you a question about the August 1st date? Is that after August 1st only for dates of service after August 1st or we can go back prior to August 1st and we just won't be available for appeal until then?

MS. ARFLACK: I think there's a date. So, if it's within the range.

MS. STEWART: Timely filing?

MS. ARFLACK: It's in the regulation.

MS. STEWART: Does it fall in line with timely filing?

MS. ARFLACK: You know like the members appeal. It follows a little bit like the members appeal, that they can do it within 30 days.

MS. BRANHAM: Then it goes to 60 and----

MS. ARFLACK: Right. It follows a little bit of that.

MS. BRANHAM: Did you all get that?

MS. ARFLACK: We sent the regulation out. That regulation is how we're going to develop it.

MS. BRANHAM: Again, you know----

MS. ARFLACK: And I know, Sharon, you're going to say it's a lot of administrative burden on us, but that's the only way we can become change agents.

MS. STEWART: At least we have an avenue.

MS. ARFLACK: Right.

MS. DYER: Three of us didn't get that.

MS. ARFLACK: We sent it to the TACs. We sent the regulations to the TACs because it was out for public comment.

MS. BRANHAM: I'll send it out again.

MS. DYER: I didn't see it as a done deal.

MS. ARFLACK: It's not a done deal. It's not absolutely a done deal. The bill was passed in this last legislative session and we have to have the process up by August 8th. So, we

sent the regulations out to you guys saying here's open comment. We gave a week because we don't have a lot of time. I mean, this was passed. We've got to get it all in.

MS. DYER: So, we just need to go back and look at that?

MS. ARFLACK: I would look at that regulation.

MS. BRANHAM: I'll send it out again. I've got it right here. I'll send it out to the membership and the TAC.

MS. ARFLACK: And as a side note. We're resembling the DOI process that they have for commercial insurance. We're kind of mimicking that. We didn't want to reinvent the wheel.

MS. BRANHAM: Okay. My followup is Cindy's information will be given, and, then, I'll send the regulation to the TAC members, as well as the Kentucky Home Care membership and informing also about the prior authorization and timeliness of that, and if not, to let me know and then I can pass it on to you, Cindy.

Okay. Home health providers in the state are following the guidelines that have

been set forth for a period of time on providing supplies to patients, and those supplies are billed and then there is a denial on the billing of supplies and it says that they have exceeded the limit when we've been told that under $250 and limits are soft and you don't need prior auth.

So, we're a little bit confused about what the denials entail when they say that they are exceeding limits. I don't think any home health agency gives lots of supplies because of reimbursement. So, the denials are coming in in regards to over the limit, a denial for over the limit.

Any information related to that?

MS. STEWART: Wasn't that the WellCare issue? Didn't we give Pat those examples at the last meeting?

MS. ARFLACK: We discussed this, Sharon, before you came in. Stephanie is here in Pat's absence today, and I'm going to follow up with Pat on what she has got.

MS. BRANHAM: Okay. That will be great.

We had information come to me

about those prior authorizations again on therapies. So, just to circle back around on that.

MS. CARTRIGHT: That's what we were discussing when you came in.

MS. BRANHAM: That goes around the whole thing and now we've got our avenue and we'll take it with that.

MS. BONSUTTO: That's where we were when you came in.

MR. BRANHAM: Okay. We have an issue that's been identified in several agencies about patients--you know, we've had discussion over the last three or four meetings that patients who have a prior authorization in place and are receiving services and the agency has checked to see if the patient is eligible at the beginning of the month for their services.

And, then, when services are provided, it comes back and says not eligible, that the patient is not a member of XYZ MCO. And we've talked a lot about agencies do not have the ability to check before they walk every time out the door to see if they are an eligible member, that we do it on good faith. When we check at the beginning of the month, we assume that they're going to be eligible

the entire month with that MCO.

And something that is happening statewide and would not be caught on checking before you went out the door and provide services is that sometimes these patients will flip one or two times a month in and out of MCOs, as well as back to the State Health Plan.

So, it could be retro eligible to another MCO or to the State Health Plan while you are providing that service, and I don't know what this glitch is that's causing this, but I think every agency is identifying this while providing services. I don't know why they're doing it, Cindy, but they are.

MS. ARFLACK: What is this in, this glitch?

MS. BRANHAM: I had to add this here because I forgot, but we've addressed it two or three meetings or longer.

MS. ARFLACK: Is this an eligibility issue? Is this the eligibility file or do you all know?

MR. STRATTON: No. What's happening is they're taking them out of one plan and switching them into another plan. And what they're

doing is they're going back and recouping the whole month. Is that correct?

MS. CARTRIGHT: Yes, or they're going to the State Health Plan.

MS. BRANHAM: Or they're flipping out to the State Health Plan and maybe retro eligible for five or six months. And, so, there you are. You provided services. You have an authorization with an MCO and then they're going in and out like jumping beans from one to the other. There's no rhyme or reason.

So, we've discussed this and we want to know other than sending one by one to Stephanie or Gregg or Robbie, what can we talk about that can be done and what is the issue with this?

MS. ARFLACK: I do know on some of the meetings I've been in, there was an issue before we started this new system, the Benefind system, that what we're doing is we're taking all of the members that were put in different ones and have been moved around and all that, we're taking the file back to the way it was before because that's the problem.

Something happened. Sorry. I'm not IT. All I can say is it was messed up, and

what we're doing, it's going to take them back to the way they were before Benefind. There's a change order on all of these members. We've taken history back. Like Coventry had them or Aetna had them and then now they're at Anthem and then they have gone somewhere else and they've been moving around. Now, we're going to take them back to where they were like Aetna, so, they'll be Aetna.

Now, I did have and I have an email and I'll be glad to send it to you but there's nothing that we can do but I did ask all the MCOs not to do any recoupments on eligibility. Now, if they're doing them----

MS. BRANHAM: Well, they're asking for it and I think most people are trying to funnel it through Gregg and Stephanie to try to get it eliminated and then they're helpful enough to get the patient eligible again.

MS. ARFLACK: Well, we've asked them not to do the recoupments because we're trying to straighten out the file. Our job is to straighten out the file.

There is supposed to be a change at the end of this month to get the files changed. There's several fixes going in at the end

of this month that hopefully will fix and make these people be back in to where they are.

Now, there are some that are showing managed care and waiver and we're trying to fix those when they come in. I don't know what the fix is for that one.

MS. DYER: I have one of those.

MS. ARFLACK: If you find those, you need to send them in.

MS. BRANHAM: For what time period?

MS. DYER: At least one person that this has been working on last October through April. I mean, I appreciate that you're trying to fix it, but here's the other problem. If you by chance don't have a contract with the MCO that they happen to land with, we need some recourse for that because that could happen.

MS. BRANHAM: They should accept that other authorization and somewhere that's been said.

MS. ARFLACK: We have that in our contract now that if this was a continuation-of-coverage issue where they have gone back and we have

retro'd them, that the other MCOs will, you know.

MS. BRANHAM: Is that in writing anywhere?

MS. ARFLACK: That's in our contract. It's in the contract.

MS. DYER: So, if they start out with X MCO and you're with that MCO, and, then, in all this mess-up and flipping around they go to Y MCO but you don't have a contract with them, then, they go back to another----

MS. ARFLACK: Like I said, they're going to go back to X, the one that you had before. That is the fix.

MS. DYER: Okay, because that has not consistently happened, I don't think.

MS. ARFLACK: Well, because we haven't fixed it. We're fixing it at the end of this month. So, hopefully, in the first of August, we will see some stability with this.

MS. BRANHAM: So, how many is that--in particular that one gone----

MS. DYER: This is all one patient that we have been dealing with.

MS. BRANHAM: And how many times has it flipped?

MS. DYER: I can't tell you from looking at this how many times it's flipped but I can tell you what she says. This Medicaid patient is enrolled in Michelle P Waiver which is probably what you are talking about and should have never been enrolled in managed care Medicaid but he has been flip-flopping back and forth.

So, I can't tell you how many times, but I asked her to give a history. So, she has done a three-bulleted point history, another page of history, another--it's unreal what we have to do.

MS. ARFLACK: I know. I understand. Gregg, are you all taking those and getting them to Member Services?

MS. DYER: So, should we give this to somebody to try to expedite because she can't get anywhere with it? So, give it to you, Gregg?

MR. STRATTON: I'll take it. We can send it up.

MS. DYER: And I actually have several of those.

MS. CLARK: I can tell you that if patient liability is not on file, that the

member will flip to an MCO.

MS. DYER: We don't do Michelle P Waiver, so, we wouldn't know anything about that because I don't do in my agency Michelle P Waiver.

MS. MARTIN: Well, it would be any waiver. It would be any waiver has to have----

MS. DYER: This particular person had Michelle P. You always say you want exact examples, so, I have tried to bring probably more specific than you want because it's a book on this and we're really not lying when we say administratively we can't afford to do this to try to fix it. And, then, the patient, they don't even know it's happening to them. We really have been talking about this for about a year but it was isolated.

MS. BRANHAM: Now it's more across the board with this issue.

MS. DYER: So, I hope it can be fixed.

MS. BRANHAM: I know it was varied just like one, two, and now it seems maybe since Benefind, I don't know, some little wormies in there or something but now it's pretty much across

the board.

MS. DYER: This has flipped like between Humana-CareSource and WellCare and this one Medicaid and Humana. And actually I have left somehow, I had a list of ten that flipped within a very short period of time. I can get them to you, Gregg, or you, Cindy, so you can see.

There is something positive on one of these, though, that Medicaid and MCOs have been giving retro PA in a timely manner when this happens, but getting to it is really difficult.

MS. ARFLACK: It's because that's in their contract that they have to go back and do those retros.

MS. DYER: Well, in Medicaid, too, but I hope you can get it fixed because, if not, it's like this staff is about to pull their hair out trying to get it done because if you think about that on one person or this on one person, and I probably could have brought more examples but I didn't think you would want them all. Some of it is not Medicaid. Some of it is managed care, but you want it all, right?

MR. STRATTON: Yes. Send me the email with the ones that you have.

MS. DYER: I appreciate that.

MS. ARFLACK: Our Member Services are very busy with a lot of these issues. We understand. We do.

MS. BRANHAM: Talking a little bit further about that, just for some clarification for members that have asked, WellCare identifies prior authorization as a post request for admission, for example, if it's done on Monday and we request the visits on Tuesday to begin for Monday's date. Would you like to explain that a little bit more.

MS. LITTERAL: Yes. In those types of incidences, they're telling us that it's a retro and they've got 30 days to respond. And, so, rather than the two days, they're saying it's a retro and they've got 30 days.

MS. BRANHAM: So, you send the prior authorization in on Monday for visits to be done on Tuesday or Monday.

MS. LITTERAL: Say they come in like the after hours on a Monday. So, you're calling in on Tuesday but you had to go Monday. Say they have IV's.

MS. BRANHAM: Right.

MS. LITTERAL: So, they're

saying, then, our request throws it into a 30-day time period for them to respond rather than the two because it's a retro.

MS. BRANHAM: See there, Cindy. I know Juan had addressed that, but really this request, if somebody had to go Monday evening after hours to perform a skill and they put their request in first thing Tuesday, it is a timely request for authorization. It's not the 30-day.

MS. BONSUTTO: That's what we were talking about earlier. If we do that on the Tuesday, then, that's considered a retro in many cases because they don't have a 24-hour/7-day place for us to call.

MS. BRANHAM: So, as far as making a recommendation, what kind of guidelines can we ask that the MCOs receive to consider that eligible for----

MR. ABREU: What is the service here? Can I ask for somebody to be more specific?

MS. BRANHAM: Skilled for intravenous fluids or something that required us to go after 4:30.

MR. ABREU: Okay. And, then,

is that the only visit or is it typically accompanied by a request for additional?

MS. BRANHAM: Well, that would be your request for that visit plus the implementation of the plan of care from the physician. It's a referral.

MR. ABREU: Right. The reason I'm asking is, without seeing a specific example, I'm not exactly sure but it sounds like it's a retro to current in which case CareSource treats that as a current which would be done following the prior authorization rules, not the retro rules, but I would just need a few more facts and we would know that for sure.

But just from what I'm hearing, it sounds like we would treat that as a retro current, meaning we treat it as a current prior authorization. And if we're not doing that, again, we would welcome examples and the ability to perform training on the team.

MS. LITTERAL: Ours are specific to WellCare.

MS. BRANHAM: Right now the current one that is in discussion is specific to WellCare.

MS. ARFLACK: Do you have examples with you?

MS. LITTERAL: Not with me.

MS. ARFLACK: This is Stephanie Jamison. She is with WellCare. Pat is gone and she can probably----

MS. JAMISON: Just for this week, though.

MS. BRANHAM: We have specific issues that relate--Humana-CareSource asked for when a prior authorization for 60 days is needed, that Humana would need to know how many would be for skilled and how many would be for LPN. The G codes for each of these changed. Why are they questioning?

So, I guess Humana, that's something specific that you will have to give to them.

MS. LITTERAL: And what that is, Sharon, is they are asking us to designate - and that was as typo when I sent that to you - between RN and LPN with the G codes that changed, with the 299 and the 300's. And we had this with another payor source early on and it got resolved, and all of a sudden, Humana-CareSource is wanting us rather

than to say we need five nursing visits and it could be - we can't tell them what it's going to be - a 299 or a combination of that and a 300, that they're wanting us to specifically ask for a specific type of nurse.

MS. DYER: I can tell you that that started July 1st. I heard about it last night from our three auth clerks. It started July 1st. That was in a Medicare Advantage Plan based on the criteria that is now being utilized, not Interqual but one of those types of services that----

MS. ARFLACK: Is it Milliman?

MS. DYER: I think it is - I could not remember the name - based on the diagnosis, etcetera, when it's run through and scrubbed or whatever "x" amount of visits and they're wanting to utilize the G codes.

And I've heard this from members of the Alliance in Medicaid, too, that we're being all asked about how many LPN and how many--we have very few in our agency but some agencies have a lot, and you cannot determine if you can send that LPN until closer to the service because you might not be able, based on KBN requirements and the scope of care, you can't send that LPN even if you've got

it planned for an RN to make four visits and an LPN to make four visits. You can't always count on that because the condition of the patient could change. So, the scope of practice is not appropriate for an LPN and you have to switch that to an RN.

So, I mean, that's a huge thing. And as I recall, the G code separation was designed for hospice so that at the end of life, if that patient needed more skilled services, i.e., an RN, that that could happen -and some of you have hospice up here on the TAC - but that was only what that was designed for, not to reserve services back in home health and that's what it's kind of turning out to be.

You can anticipate it but you can't be held to that because you could split it right down the middle and then need all eight RN visits in a plan of care or twenty or whatever you might have for somebody, and I don't think I'm alone in thinking that for people who have LPNs. I know probably all of us sitting up here have some, the same as what they're talking about.

MS. JENNINGS: So, I can answer that from our point of view for the G codes. Early on we were having some issues with that. We

did some training with our staff and they should not be requesting clarification on those two.

From our side, we don't really need to know whether it's LPN or RN. So, that would just need some additional training on our part to let them know that they do not need specific visit amounts for each type of nurse.

MS. DYER: I think it was brought up before and I think I was the one that brought it up because of the Knox County issue with this back last year.

MS. ARFLACK: So, it sounds like that's resolved.

MS. BRANHAM: If it doesn't, we just need to be notified.

MS. JENNINGS: It should be, yes. It should be. I will definitely educate the staff and let them know that they do not need that level of detail.

MS. BRANHAM: Okay. And as far as additional questions that we received, I think Passport is working on those codes and I think they were sent out to the membership. They were sent out to the membership about a week and a half ago.

And, then, as far as your question, Darlene, with Aetna, I think you need to probably touch base with Laura.

MS. LITTERAL: We have. We just haven't got a response.

MS. BRANHAM: Again, getting followup has been our most difficult task to date. Even if we do send information as we're requested to do on specific information, I know that the designated MCOs are busy but so are we, and to have to keep saying have you reviewed it, where is it, oh, I don't know, can you resubmit it, it's just over and over and over.

And I would think that it could be sent to someone who has the authority to act on this and provide an answer within at least five working days in regards to questions and issues that agencies have, whether it's types of bills, because usually agencies are following the codes and agencies know what type of bill and it's somebody somewhere else that hasn't got the proper training all down through the rank and file of an MCO to get these things taken care of.

So, I guess, Darlene and Joyce, I would suggest that you send your

information again to Laura and copy Cindy on it perhaps and that may get some resolution.

MS. ARFLACK: We have started writing some corrective actions in relation to them not responding to us and to providers.

MS. BRANHAM: Okay. That would be helpful because you just do it, do it, do it, do it and we all know now that you provide----

MS. ARFLACK: We're frustrated sometimes just as you all. There's been some turnover in staff but they will have to figure that one out. We feel like if the provider is doing everything, then, the MCOs should be able to at least respond. We're not saying that the MCOs are wrong. We're saying that the MCOs get you a response.

MS. BRANHAM: Give us a response. Thank you.

Talking a little bit about 552's, let's move on to 552's. 552's seem to be hanging out in nowhere land and getting resolution for these.

And I guess Gregg has provided to us some help with phone numbers in regards to the MAP 552, and we know to provide that information.

And I don't know if it's going to help us or not, but I know that my staff told me when they go in and they look at the dashboard and they've completed all of their information, perhaps somebody has passed in November of '15, that they still have a task opened to discharge and it's like we did that and it's not getting through to the information board like it should be.

MS. BONSUTTO: How often does that update? Does it update nightly or weekly?

MR. STRATTON: Which information are you talking about?

MS. BONSUTTO: She's talking about to the dashboard. What I heard her say was she goes in and discharges the patient in the system, then the dashboard is showing them a to do item to do that like it's not been completed. That's what I heard.

MS. BRANHAM: Yes.

MR. STRATTON: On MWMA?

MS. BRANHAM: Yes. And the 552's are out there. We don't know what to do about this.

MR. STRATTON: I'm not sure how those relate. As far as the program closure, if

there's a program closure, it was being able to be initiated by the provider, but I was just told recently that we're going to be doing those here at DMS. So, I don't know how we get that information to close them out.

MR. GRESHAM: If you will send us information about the ones that keep showing up as needing to be completed again, then, we can look into it and see what the problem is.

MS. BRANHAM: Okay.

MR. STRATTON: Yes. We can close those out on our end.

MS. BONSUTTO: So, I just heard you say that the providers are not going to be closing. So, if someone passes away and they no longer need waiver and we need to tell you that or they went in to a nursing home----

MS. BRANHAM: Well, we have to go in there and do our discharge.

MR. GRESHAM: We still have to go in and do that, but DMS will be going through it and collecting approved or----

MS. BONSUTTO: Okay. That's what I was trying to understand. You all have an additional process.

MR. GRESHAM: Yes. You will still do your little thing. It's just an additional task for us.

MR. STRATTON: When I get that policy and how it's outlined, I will send it to you because I was just notified of that this week. I had another provider in a similar situation. They couldn't close one out. We can see it but I couldn't close it out either. So, I've got to figure out how to do that.

MS. BONSUTTO: So, you want a list of any of those that are sitting on the dashboard.

MR. STRATTON: Sure.

MS. BRANHAM: Has anyone had an expedited assistance with this on the MAP 552 from this 1-800 number? Billie, do you have any experience with it?

MS. DYER: Yes. My Home- and Community-Based Waiver coordinator has had some experience with it. And, Gregg, I think I might have sent this on up to you. Part of that was sent to Gregg anyway but she didn't have any luck with it. The time that she tried to use that, it was still----

MS. BRANHAM: And to email this MS.Services@ky.gov, it seems like they're still hanging out there.

MR. STRATTON: We're getting some back and some might take four weeks, and I know they are under-staffed and overworked at the time. So, as we get those individually, we're sending them up asking them to review them and get them resolved. And as they do, and Darlene can attest, sometimes they're very lengthy but we are getting some resolutions and they are becoming fewer and fewer. So, I do see some light. It's just not a very bright light at this moment but we are working through it.

MS. DYER: There's a little glimmer right there.

MR. STRATTON: And we'll continue to send them and get them resolved.

MS. DYER: I think she just didn't get a response or couldn't get through. That was what she was thinking.

MS. BRANHAM: Or if it goes, you don't know that it was accepted.

MS. DYER: You don't know. That was her thing. So, it may be there and she

just didn't get any response.

MR. STRATTON: And if I need to check one of those individually, I'll be glad to. You can call me or send me information on an email and I'll be glad to look it up for you.

MS. DYER: Thank you.

MS. BRANHAM: The next is MWMA and waiver. So, we have noticed that this week there's been trainings going on to kind of refresh and re-educate on the system, and this kind of goes hand in hand I guess if you're doing waiver.

We have difficulty when we enter the system on doing the tasks that need to be done. And, so, really, instead of it being, Gregg, we've covered under waiver the process for 552's, no ability or any way to expedite it, and, then, the Department of Social Services and Medicaid, I mean, it can be--you have a patient, say, for example, on Model Waiver II on a vent for six, seven years and every month they've got to go in and reestablish eligibility.

So, that takes a period of time because they--or when they take the information, it's like the folks there that they take the information to aren't requesting or aren't

entering the correct information and there's a lag of two or three months trying to get these vent patients eligible again so that agencies can bill for service.

Is there any way that they can be told what's going on?

MR. STRATTON: I wasn't aware of any of this. So, if you want to get me some specifics on that, we can look into it. I've not heard from too many Model II members or providers. So, I wasn't really aware that we were having some issues.

MS. BRANHAM: Okay. When you go into the system, we usually go in under DDE look and see their last current address, talk to them, have their phone number, have their address, and then we try to go enter them into the system and we can't because their addresses don't match and that's like the stopping point then.

And I know this is coming up in the waiver the Governor has put forth because the numbers, the mobile numbers, the pay-as-you go numbers, the addresses, you know, it's a real disconnect among all of that. And I don't know how this is going to work in providing care when we come

to a wall because the address doesn't match from what was printed under DDE to what is in the system. How are we going to do that?

MS. CARTRIGHT: I don't know but it happens.

MR. GRESHAM: The address does have to match in MWMA--let me back up a little bit. The waiver that the Governor has proposed has absolutely nothing to do with us at this time, has nothing to do with waiver.

MS. BRANHAM: Yeah, but it's going to be--again, you know, we're just trying to look beyond today.

MR. GRESHAM: Okay, but as far as today goes, yes, the address has to be correct in MWMA for that information to be uploaded. They have to correct their address with DCBS. We're not able to do that. Medicaid is not able to do that at all. It has to be done through DCBS.

MS. BRANHAM: But why? Say you are admitting a patient and you go under DDE and you get their information and that's the information you put but it's not the information that's loaded into the system, you would think that that information populates that system. Why doesn't it?

MR. GRESHAM: It seems to me like the information has already been entered in at some other point.

MS. BRANHAM: But it looks like that the system and the DDE could talk. Every other day they populate it with updated phone numbers or addresses because you've got one system that's telling you this and then you go to into this other system and it's like but that's what we just got off of that system.

MR. GRESHAM: What is DDE?

MS. BRANHAM: A place to inquire about the patient's eligibility.

MS. BONSUTTO: Eligibility verification for anybody, if they're Medicare, if they're MCO.

MR. GRESHAM: So, is it a state system or a federal system?

MS. CARTRIGHT: Direct Data Entry system.

MS. BRANHAM: Yes, DDE, Direct Data.

MS. CLARK: I was going to say, ours goes through KYHealth-Net.

MS. ARFLACK: That's what I

was wondering, if it's our MMIS.

MS. CLARK: No. DDE is not.

MS. BRANHAM: That's how we check Medicaid eligibility.

MS. ARFLACK: You don't use KYHealth-Net?

MS. DYER: We do.

MS. BRANHAM: Yeah, but it still doesn't----

MS. BONSUTTO: I think it goes from the Health-Net or wherever it's all in, and I think it all pulls up through DDE. It's a private thing that all providers pay for.

MS. BRANHAM: But they have to get it from somewhere. So, we're saying how often is it populated?

MR. GRESHAM: I don't really think that's our system.

MS. BRANHAM: Okay, but if we go to your system and we see the address and we go to this system to try to enter a patient, they still don't agree. That's what I'm saying. Why when we pull information from the State do they not agree and how often is that updated?

MR. GRESHAM: They being DDE?

MS. BRANHAM: No. They being the two systems.

MR. GRESHAM: KyHealth-Net and MWMA?

MS. BRANHAM: Yes.

MR. GRESHAM: Any idea, Pam?

MS. SMITH: We get the information from them. We get the information from Benefind and that's where it comes from. So, it should be whatever they have in Benefind should be what we have in Health-Net. Now, I do know in MWMA, there's some instances where the providers actually load an address sometimes when they are putting people in.

So, I don't know if maybe that's where some of the disconnect is, but as far as Benefind and Health-Net, those should be in sync because unless it's just a point in time where there's a gap where we just haven't got the file that night, but we get a file every night of member information.

MR. GRESHAM: If you can send me a couple of examples, I can try to backtrack it and find out what's going on.

MS. STEWART: Which one is

sacred?

MS. ARFLACK: Well, our system is what we would say the source of truth, but I don't know how this interacts with----

MS. SMITH: But Benefind is the source of the data. So, that's where all the changes have to originate from.

MS. DYER: So, then, what's on KYHealth-Net should be it.

MS. SMITH: Should match, unless the change has been made within that day and just the file has not come yet, but those two should be in sync with each other.

MS. STEWART: So, if there is a disconnect between Benefind and DCBS, is that who you said has to correct it there?

MR. GRESHAM: Yes.

MS. STEWART: Do those ever talk?

MS. SMITH: That's where they are making the correction.

MS. MARTIN: In Benefind. DCBS was the entity.

MS. SMITH: DCBS is the people, DCBS being the people and Benefind is the

tool that they're using.

MS. MARTIN: They log in to Benefind and update Benefind.

MS. DYER: So, the disconnect, then, is MWMA doesn't match Benefind and we have to go to DCBS so they can update Benefind so that it will match the----

MS. SMITH: That's what it sounds like. I think that's why Earl needs the examples, I think, so we can kind of backtrack to figure out to get to that.

MS. DYER: But I know what Missy and I think I know what they're talking about, too. We can use a clearinghouse to connect up with DDE for federal or that kind of thing or Health-Net for Medicaid because it really saves a lot of staff time to do that.

MS. BRANHAM: Rather than going three places.

MS. DYER: Rather than going three places or have two somebodies or three or four somebodies spend all day long checking on your Medicaid, you can pay for a clearinghouse to do that. So, that should not be the problem. How we connect with it shouldn't be the problem.

MS. BRANHAM: The problem is the inaccurate data.

MS. DYER: Yes, that they're not matching. And, Gregg, some of those examples I gave you, they don't have any kind of waiver that we're aware of. So, I don't know if you want all of those.

MR. STRATTON: I'll sort through them.

MS. BRANHAM: Okay.

MR. GRESHAM: I also wanted to clarify one thing. You mentioned that there was MWMA training going on this week and it's not. It's waiver, the HCB Waiver. I wanted to clarify that.

MS. BRANHAM: What should be an agency's ability to go into your system for a waiver patient and enter the data to start services and they come to a roadblock because of the fact that the address is wrong or somebody hasn't entered information, and then we'll call the number and then it's like, oh, my gosh, forty-five minutes on hold to say, well, you're not using the new system. Well, yeah, I am. Well, then, you should be using the old system. Well, I just put a patient through under the new system. It's really difficult to

navigate.

MR. GRESHAM: Have any of the HCB providers taken the EKU training?

MS. BRANHAM: I think everybody has.

MR. GRESHAM: Okay. There's job aids in the EKU training and then there's also a user manual that gives a step-by-step on the thing. So, we're reminding providers of that. And, then, yes, when you run into a specific issue, we ask that you call the Contact Center. If you don't get a resolution from that Contact Center, call us or email us and tell us what's going on.

MS. BRANHAM: Well, you know, I think that these long waits on the phone to try to get something answered is a problem because we already have a few agencies that are going to provide this service. I don't think we've got enough information right now for anybody to say they are or they aren't. But the more issues that we run into, the less ability we're going to have for people to provide this service.

MS. BONSUTTO: I have a followup question to what you just said. You said if they don't take the EKU training, then, call the

Contact Center. Are you talking about this 1-800 number on here or something else?

MR. GRESHAM: No. It's a different 800 number.

MS. BONSUTTO: Okay. And, then, you said or email. Who should they email?

MR. GRESHAM: If you don't get a resolution, then, email us.

MS. BONSUTTO: Who is us?

MR. GRESHAM: Me and Gregg.

MS. BONSUTTO: Okay. That's what I meant. Okay.

MS. CARTRIGHT: Gregg responds very timely. I will say that.

MS. BRANHAM: I'm going to stop there before we go further and let's talk a little bit about the training going on and issues and problems that waiver providers are having.

MS. DYER: Before we move to waiver, Sharon, I don't know if you got this email I sent you or not last week. You may not have received it, but I have the contact name and the agency name. And what she says is they're getting denials for incontinent supplies a lot for no PA when none required, denials for modifiers for

supplies, for Medicare EOB's for the incontinent supplies, some denials for no PA when we've actually had one even though one is not required.

So, who should she reach out to for that? I can give her your contact. All these are from Aetna and WellCare. For the most part, I am the contact person but she's not had any luck getting this resolves, I guess. So, you guys, Cindy? Send it to you?

MS. ARFLACK: Please.

MS. BRANHAM: And that's what I alluded to about----

MS. DYER: That's what you were saying. I wasn't sure.

MS. BRANHAM: Under supplies, yet, you know, they don't require a PA. Then they're denied because of no PA or they don't have an EOB attached to them when the qualifier code----

MS. DYER: Here's one of your persons that has that. So, when I get your contact, I will tell her to contact you.

MS. ARFLACK: Okay.

MS. BRANHAM: Is that everything so far?

MS. DYER: Yes. I just wanted

to clarify that I had that.

MS. BRANHAM: It needs to go to Aetna, WellCare and Cindy.

MS. DYER: Well, I think it's already gone to those two.

MS. BRANHAM: Well, it needs to go again and copy Cindy.

MS. JAMISON: Who at WellCare?

MS. DYER: I don't know.

MS. BRANHAM: Pat is usually who we send stuff to. Stephanie, do you want to be the second person?

MS. JAMISON: I do actually.

MS. BRANHAM: Okay. Let's talk a little bit about the EKU. There is training occurring currently as we speak, and I think everybody that is going to this will probably shortly make up their mind if they're going to provide waiver or not, I would say. What did your staff bring back from the meeting yesterday?

MS. CARTRIGHT: Well, I just got an email. It's my staff in the western part of the state and their concern is there are very few providers who are willing to provide the actual care. There are lots of providers who want to do

the case management. So, the concern is how is that going to work because if we have to provide all the care, we won't be able to do it. We can't even hardly break even now with the rates. You really can't. So, are these people who are not going to do service, are they going to get all the case management?

MS. BRANHAM: Let's walk through this a little bit about I guess that the AAA's or the AD Districts are the ones that are going to be funneling out the referrals and case managing along with the nurses that have been contracted. Is that still the way we're going?

MR. GRESHAM: I'm not sure what you mean by the ADDs funneling out the referrals. What will happen is the people will be uploaded into MWMA system. The people who are in there now should already have transitioned into the MWMA system.

Starting August 5th, the people that are due for LOC on September 15th will be reviewed by the nurse assessors. They will do the LOC assessment. They will upload it to the system, and then CareWise will determine whatever they determine and then it will proceed on.

The member is required to pick who they want as a case manager and then the case manager will help in the plan of care meeting once all the eligibility has been determined. The case manager will help the member establish in the plan-of-care meeting who does what.

MS. STEWART: And what if the case manager makes that declaration and there's no one there to provide the service?

MR. GRESHAM: Then that's when we have to start down that road.

MR. STRATTON: Well, we do have consumer-Directed or Participant-Directed which we use in a lot of rural areas where we don't have home health or adult days which is not always the best response but we still will have that option.

MS. BRANHAM: Mostly because the cost involved with them getting their folks there that are going to be providing their care is out of their pocket.

MR. STRATTON: Yes.

MS. CARTRIGHT: It is very concerning to me that we're going to have patients that aren't going to be able to get care.

MS. STEWART: Is there an

attempt by the State to send out a news declaration of what current providers intend to provide in the future because we a year and a half ago said we might do this, we might do this. We're definitely not doing that. Are you going to send that out and see who is willing to even stay in the program?

MR. STRATTON: Yes. We--well, not we. The Department for Aging and Independent Living who will be administering that program has sent out on multiple occasions a request for providers to say what services do you intend to provide and what counties do you wish to serve so that when they create their master list, that name can be included.

If you have not received that, I will ask Robbie to get that information from Dale and we'll have that sent out.

MS. BRANHAM: I think we all completed that some time last year.

MS. STEWART: We got it one time but nothing----

MS. BRANHAM: Nothing in the past eight months.

MS. BONSUTTO: It might be a good idea to make sure and update those people to

verify that people have still the same commitments it sounds like than they did it before.

MR. STRATTON: Right. We'll revisit that. A year ago, we really were a lot more in limbo than we are today. Today we have a direction and a time frame of where we're going.

MS. STEWART: So, Earl, what you're saying is anyone who has to be reassessed after 9/15 will be put under the new waiver and they will be conflict-free case management from that point forward?

MR. GRESHAM: Correct.

MS. STEWART: And, so, for a patient that we have today, on 9/15 when they are reassessed, we will either be their case manager or their service provider, not both, and maybe none either.

MR. GRESHAM: Correct.

MS. BONSUTTO: We get a lot of calls. We do a lot of waiver. So, we get a lot of calls and then we will be directing them to the process of how to do that. It sounds like if we get the referral and we are willing to do either the care or the case management, we have to talk to the patient to make sure that they tell them that they

would want to use us. We have to make sure of that because the AAA and the nurse is going to sit down with them at that time and do that. Is that correct?

MR. GRESHAM: Everyone has to be uploaded into MWMA. So, if you choose to assist them with that application, getting them uploaded into MWMA, that's your choice.

As far as providers being able to see that Robbie is a new HCB member and he's going to need case management and all those services, no one will know until Robbie reaches out to whoever he reaches out to.

MS. BRANHAM: The patient reaches out?

MR. GRESHAM: The patient is responsible.

MS. BRANHAM: That's going to go well. That ought to go really well.

MS. BONSUTTO: There's not a way to call the AAA and say I sent you this referral, it's coming through or anything like that?

MR. GRESHAM: No. That's correct.

MS. STEWART: Have the

patients been notified that come 9/15, that they're either giving up their case worker or their certain provider?

MR. GRESHAM: I would hope their case management agencies have been telling them since this process has been coming for a couple of years now.

MS. DYER: I really don't think that's been happening because I don't think we've had any real clear-cut, like you said, we didn't really know and now we have direction. So, I think we need that----

MS. BRANHAM: I don't think these folks are going to be----

MS. DYER: ----so that that doesn't look like that's coming from our individual agencies because it's really got us----

MS. STEWART: It looks like we're abandoning them.

MS. DYER: Yes, it will, if there's not something from the State that you all can give us that we can give to them and then we tell them to call you all because it's going to look bad on our end when we say, sorry, you've got to pick one or the other or we're out.

MS. BONSUTTO: But, then, we need to tell them they need to pick us for this one or that one because we've got to tell them which one we're going to be doing or both or they have to choose. So, I think there has to be something out to these recipients of what's going on, some sort of communication.

MS. BRANHAM: So, I'm going to make a recommendation that Dale or the Cabinet or whoever will send out a communication that as of 9/15 that if you are under a waiver plan of care, you're going to have to choose, at your next recert, that you're going to have to choose your provider and your case manager.

MS. BONSUTTO: And if we could get a copy of it because not a lot of people read their mail or somebody else gets it or it got lost so that we could say, hey, did you receive this letter. We want to let you know this. I mean, that's starting like next week. So, we've got to get this out real soon.

MS. DYER: I think Missy has a good point. If we have that in hand, then, when we go, we can follow up with a copy or know exactly what points consistently to refer to, but I'm just

kind of hearing all around me the patient population that mostly is served, at least by Home- and Community-Based, not maybe some of the other waivers, but the one that we do, these patients, whatever you want to call them, participants or whatever, I just have to say this, do not have the wherewithal to reach out.

I know it's not your all's fault that it's set up this way and I'm not saying that it is, but I just have to go on record saying that, once again, and I think I'm hearing a murmuring of the same concern.

I don't know what's going to happen to people because they can't reach out. They can't hardly go down and get things straightened out at DCBS.

MS. BRANHAM: Not without a lot of direction.

MS. DYER: Well, and even with a lot of direction----

MS. BRANHAM: And then with a lot of direction, it doesn't always work out.

MS. DYER: Well, and sometimes that means that we all go do a whole lot of free stuff to help them get it, and we're going to have

to do so much more free stuff than this that I just don't know what's going to--I'm just really worried about the patients.

MS. STEWART: What's going to happen in my area is I don't think there's going to be many, if any, service providers. And on the original application, I put that I was going to do that. And, so, then, KRADD will automatically get the case management because that's all they're going to do and that defaults me automatically to service provider only which is not going to happen.

MS. BRANHAM: That's why I said, I mean, you know, and I know over the past few months, the AAA has called in "a referral" without even discussing if this patient qualifies for services and the steps they have to go through to see if they qualify. So, we're trying to help them see if they qualify but they're just dishing out names and numbers and giving it to agencies and no real direction, and some AAA's are better than others.

But I see home healths being the folks that are going to be stuck with pretty much the provider, and as the Commissioner said a long time ago, the AAA's lost their money and

they're trying to get it back to them. So, I see this as a problem.

MS. CARTRIGHT: Should we also in the recommendation let members know they have CDO and PDS as an option?

MR. STRATTON: You're saying in your recommendation to let them know that? You could. I mean, we don't want to leave them stranded.

MS. CARTRIGHT: We don't want to leave them. That's why I'm saying, especially if you get into a situation where there's no service provider.

MS. BRANHAM: And we have to be very well-versed on what CDO involves more so than PDS even.

MR. GRESHAM: Well, HCB will be PDS. It won't be CDO anymore.

MS. BRANHAM: Well, okay.

MS. STEWART: Do you know the format of the 9 to 4 trainings?

MR. STRATTON: Yes. I don't have it in writing but they do have a PowerPoint that she goes through that covers the PDS in the afternoon. It covers the waiver-specifics in the

morning. It's very interactive.

MS. STEWART: Robust?

MS. CARTRIGHT: My folks said it was very interesting yesterday.

MR. GRESHAM: I would agree with them.

MS. STEWART: The reason I asked is I'm going Friday but I want to be there for the robust part and to make my point and then I want out.

MS. BRANHAM: So, are you asking should you go in the morning or afternoon?

MS. STEWART: Yes. That's what I'm asking.

MR. STRATTON: You will want to get there early. And a lot of the questions we've had such as some of the reimbursements were cut. The conflict-free, that came from the federal government. We're just passing it along.

MS. BRANHAM: Right. We get that.

MR. STRATTON: But as far as going from a medical model to a social model, that was the intention of the waiver designers which, as I mentioned, was being administered by a different

department. So, it's not a good answer but we were cut out of a lot of the contribution of that.

MS. BRANHAM: I understand. So are we.

MR. STRATTON: So, I would encourage you to attend the training this week, ask the questions and we'll go from there.

MS. STEWART: Is billing addressed tomorrow?

MR. STRATTON: Billing?

MS. STEWART: Billing the services, specifics about billing?

MR. GRESHAM: If you ask those questions, it will be addressed. I don't believe it was part of the PowerPoint.

MS. DYER: So, how are we going to get further direction on that? Do you know?

MR. GRESHAM: Ask the question.

MS. STEWART: Ask the question, just like he just said, right?

MS. BONSUTTO: That's just scary that the only way that people will know what to do is if they go to training and happen to ask

the question. It seems that that would be part of the training would be, all right, are they going to change the billing process.

MR. GRESHAM: And to my knowledge, we're not changing the billing process. It's done in MWMA. As far as the services you request, it updates in MWMA. CareWise issues the PA and you bill as normal.

MS. DYER: Well, but----

MR. GRESHAM: But if you have specific other questions----

MS. DYER: ----it's not as easy as that sounds because there hasn't been attendant care. I mean, there's always little specifics when it comes along. Do you know what I'm saying?

MR. GRESHAM: I do, and those little specifics obviously----

MS. BRANHAM: What do you mean there hasn't been?

MR. GRESHAM: ----aren't going to cover all of them we need to be asked.

MS. DYER: There hasn't been attendant care in waiver. I'm sorry?

MR. GRESHAM: The little

specifics, we're not always going to know so that we can communicate with you. There are things that were brought out in the meeting yesterday that we hadn't considered yet. So, I was on the phone making phone calls to make sure we took care of it.

MS. DYER: I mean, there's been personal care but not all-day attendant care. That's a whole different rule.

MS. BONSUTTO: Yes, if it's a new service.

MR. GRESHAM: And those are discussed.

MS. BONSUTTO: So, they are going to touch on the billing of the new service.

MR. STRATTON: It's descriptions of and qualifications.

MS. STEWART: And is that put up on a screen or do we walk away with it?

MR. GRESHAM: It's on the screen and eventually you can get it.

MS. CARTRIGHT: I asked him to send it to me and they said there wasn't one.

MR. GRESHAM: Send me an open records' request.

MS. BONSUTTO: I just want to

verify what I heard. So, we have this new service that we've not been able to bill for before, and we don't know how to bill for that. That's not specifically set in writing in the PowerPoint or anything we can have a copy of.

MR. STRATTON: She promised to get a copy out. Because the training was so quick on the approval - the approval we just received two weeks ago. So, they kind of rushed and got the training put together and not a lot of the training material was revised from the previous where we had gone out last year and had the same road show. So, some of it hasn't been revised.

So, because the trainings are somewhat dynamic and questions are being asked, they're revising the training as they go. Once they're finished, they have promised to send that out to the people who attended.

MS. STEWART: Who are the presenters?

MR. STRATTON: Yesterday was Evan Charles and Tonya Wells. That was in Bowling Green.

MR. GRESHAM: I know Tonya is presenting today and that's why she wasn't here. I

don't know who is with her.

MS. BRANHAM: All right. So, really, if we were active last year, then, we don't really need what they're presenting right now because it's not truly been updated and we should wait until they finish. And isn't Friday the last one?

MR. STRATTON: I would encourage you to attend if you haven't.

MS. BRANHAM: I know, but I mean to request what they're putting together or what the final driver is going to be.

MR. STRATTON: They will send that out, but there are a lot of questions that are being asked throughout. So, like Earl mentioned, we learned a lot yesterday that we weren't aware of.

MS. BRANHAM: Do you have anything else to tell us?

MR. STRATTON: There will be the HCB 1 and 2. There will be a by a one-year transition period, people will transition during their level of care.

MR. GRESHAM: Just like what happened with SCL when we went to the new waiver.

MR. STRATTON: So, not

everybody is going to get attendant care on September 15th or home-delivered meals. Those will be added as they meet new level of care.

MS. DYER: I do have to ask. How many nurses are in place to do assessments and reassessments? Do we have an answer?

MR. GRESHAM: Right now there's 19. There's going to be 23.

MS. BONSUTTO: Do you have coverage across the state right now with the 19?

MR. GRESHAM: Correct.

MS. BRANHAM: And does it still stand that we meet them in the home?

MR. GRESHAM: They won't meet anybody in the home except for the member.

MS. BRANHAM: And they'll explain then I thought about their choice for case management and provider services.

MR. GRESHAM: Right.

MS. BRANHAM: So, I would think that it would be nice for them to have an updated list to present to the recipients.

MR. GRESHAM: What they will do, they're not in any way determining level of care. They're just doing the assessment. What Dale

I believe has mentioned is they will provide them with a refrigerator magnet or something similar with Dale's contact information if they have questions.

If they do meet LOC, then, they will receive a letter with a web page and a number to call regarding choosing a case management agency to develop plan of care. They won't be carrying a provider list out.

MS. BRANHAM: And you think that these recipients are all going to have a device to connect to the Internet?

MR. GRESHAM: That's why the number is also on there because I don't think they will all have a device.

MS. BRANHAM: Well, okay. It ought to be interesting. All right. Any other thoughts or insights? Rebecca, you've not attended. Billie, you've not attended.

MS. CARTRIGHT: Some of my staff attended.

MS. BRANHAM: Let's move right along because we're short on time.

Let's talk about private duty.

MS. ARFLACK: Is this related to the waiver, the 1115? I just wondered because we

had some questions. We've had some questions submitted regarding the private-duty nursing on the 1115 Waiver, the process that the Governor has proposed. All of those are being compiled. So, I didn't know.

MS. BRANHAM: I think this is a twofold kind of thing for private duty. You can either be a home health agency and provide it and your provider type is 34, or you can be a private duty, have a CON for private duty and that provider number is an 18 and talking about home health agencies have to get a provider type in order to bill for any services that they may provide. And I don't know that all home health agencies know that if they're going to provide private-duty services, that they have to have the 18 provider type since now home healths can provide private duty.

MS. ARFLACK: Is this what Gregg gave out, this right here?

MR. STRATTON: Yes. Robbie put that together.

MR. EASTHAM: I think that was just to let the home healths know that this is out there. There's not a lot of home healths participating in PDN, and it could be another avenue

for revenue and whatnot and to increase patients because in the regulation, it will tell you, you can provide up to 2,000 hours, six months, 8,000 a year, I believe.

MS. BRANHAM: Well, those numbers may have moved under the new----

MR. EASTHAM: I don't have what I gave you all out there. I've got everything else but that, but the rates are comparable. It's like $9 for fifteen minutes which constitutes one unit which that comes out to what, $36 per hour.

MS. BRANHAM: Ninety-six units. There's where it is talking about it, Robbie.

MR. EASTHAM: Ninety-six units, okay, per participant per 24-hour period.

MS. BRANHAM: Yeah. It's 8,000 units and that's down from what we could have done before.

MS. SMITH: That's a soft limit, though. If it's medically necessary, they can receive whatever amount that they need.

MS. BONSUTTO: Is that then back in review afterwards?

MS. SMITH: No. You request a

prior authorization. It requires prior authorization from the first visit.

MS. BONSUTTO: I understand that.

MS. SMITH: So, it is from whatever get-go. Then if you need to modify, yes, you can modify it and----

MS. BONSUTTO: I guess I'm a little concerned and probably my history of being in this for a while is if we get prior authorization and then it's a soft limit, are we going to get denials for being over the limit on the back end even though we got auth?

MS. SMITH: The way the audit was designed, they suspend and it gets reviewed. If the auth is there, it gets paid. There's nothing else that you have to do as long as the authorization is there.

MR. EASTHAM: I would just encourage that home healths have the information and seek licensure provider type 18. If Catherann Terry would speak on this.

MS. TERRY: It's not licensure. Provider Enrollment doesn't license a provider. They enroll providers. So, home health

agencies will have their home health agency licensure and their own CON and those are accepted to enroll to participate as a Kentucky PDS, Provider Type 18. I didn't want them to think that they had to get a private-duty nursing licensure.

MS. BRANHAM: But they can't bill unless they are enrolled and have a Provider Type 18.

MS. TERRY: You've got it.

MS. BRANHAM: Were there any other changes that relate to private duty with waiver or a level of care to qualify for private duty? No.

All right. Any other comments or questions, concerns, suggestions?

MR. EASTHAM: Sharon, Catherann is also here under Other if there were any questions concerning EPSDT.

MS. BRANHAM: Do you have any EPSDT questions?

MS. DYER: An EPSDT Special Services' question. From what I understood, that after we had our last TAC and I guess then MAC, we are getting more approval for what is requested, what is ordered by the physician.

MS. BRANHAM: Rather than?

MS. DYER: Rather than not--I do think that there are still lump sums of visits coming that are way minimal from the duration that they asked for and that can easily be misinterpreted by our therapists to think that it's being decreased.

So, we're working with them to say we just have to call back in, but I would still think that's something that needs to be looked at, that if we have a patient on plan of care and I think one of those examples I gave Gregg is to do with a child--actually, you've got everything I brought. One of them is a child that was denied on EPSDT Special Services. So, you might want to take a look at that or somebody.

MS. TERRY: Let me ask you a question. What type of services are we talking about?

MS. DYER: EPSDT Special Services therapy.

MS. TERRY: Like physical therapy, occupational therapy?

MS. DYER: Physical, occupational.

MS. TERRY: Those are our State Plan services just as the private-duty nursing.

MS. DYER: Have we gotten any notification that that switched?

MS. ARFLACK: Yes.

MS. DYER: When did we get that? I didn't get it. We got it saying it was going to happen last year but it was rescinded and I haven't gotten anything since.

MS. ARFLACK: No. It wasn't rescinded.

MS. DYER: Yes, it was rescinded last year.

MS. SMITH: The change was it allowed you to bill with your 45 provider type, not the policy around it.

MS. DYER: Yes, it's the 45, but we did not have to go to that State Plan last year. We did not have to change.

MS. TERRY: Correct. There was a postponement in June of 2015.

MS. DYER: But we didn't get anything saying that that had been reinitiated.

MS. TERRY: That's correct.

It has not yet been initiated. So, as of now, if you have a Provider Type 45, understand, you are still probably getting prior authorization and billing under that provider type.

MS. DYER: We'll change it to the State Plan whenever we need to.

MS. TERRY: And we're working on that. We have a time line for that.

MS. BRANHAM: So, we're still under the 45 that we're billing our EPSDT.

MS. TERRY: Okay. So, I just wanted to clarify and make sure that we're talking about EPSDT Special Services Provider Type 45.

MS. DYER: We're talking about EPSDT Special Services.

MS. TERRY: And fee-for-service member.

MS. DYER: Yes. I mean, we've been being told that was going to happen soon. Is that really soon?

MS. TERRY: No, not really soon. I would let you know if it was really soon.

MS. DYER: Okay, because first I was hearing it had already happened.

MS. TERRY: No, ma'am.

MS. DYER: It's not happened yet.

MS. ARFLACK: It has for the rest of the world. They are already billing under the State Plan.

MS. DYER: Can we bill either right now? Is that what you're saying? Can we bill either Special Services or can I put it to the State Plan?

MS. SMITH: You can put it to the State Plan now, yes.

MS. DYER: Can I have something in writing saying that because we can start transitioning if we need to. If we need to do it, then, we can start looking at it.

MS. BRANHAM: It would be helpful.

MS. DYER: The fee schedule and all that, we would have to look at all of that.

MS. ARFLACK: I think that's why they haven't transitioned because of the fee schedule.

MS. DYER: So, we need to stay with what we've got right now. Okay. But, anyway, in a long-duration patient with a chronic

congenital, very severe diagnosis would not still be getting 20 visits for a long period of time----

MS. BRANHAM: Six months.

MS. DYER: Three months or six months. So, that easily can be misconstrued, but the clarification that I understand here is that if you need more, you've just got to call for more.

MS. TERRY: That's my understanding.

MS. DYER: But you can see how that's a lot more work to do that when they're going to stay on for a long time, ever.

MS. BRANHAM: But at least we got a little more than five visits.

MS. DYER: Yes, more than ten. So, it has much improved. Thank you very, very much.

MS. BRANHAM: Any other business? Our next meeting is September 21st. Thank you all for your participation and we will be following up with all of our direction.

MEETING ADJOURNED